Public Employees Health Program

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004
Customer Service: 801-366-7555 / Toll Free 800-765-7347

State of Utah

Group Term Life
Enrollment and Change Form

Section A

Employee Information

☐ New Enrollment ☐ Status Change (Please specify type): _____

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS ☐ Single ☐ Married	GENDER ☐ Male ☐ Female
HOME ADDRESS	CITY / STATE / ZIP		WORK PHONE	
EMPLOYER / DEPARTMENT		HIRE DATE (mm/dd/yy)	HOME PHONE	

Did you transfer from another Agency/Department? ☐ Yes ☐ No If Yes, which Agency/Department? _____

Section B

Coverage Information

Select the desired coverage below. See the Term Life Benefits Booklet for cov erage and premium amounts. Enter the primary and secondary beneficiaries for Employee & Spouse Term Life Coverag e. If you elect to enroll in dependent coverage, the beneficiary for each insured dependent is automatically the insured employee. Coverage amounts are reduced at age 66, see Benefit Booklet for details. If the spouse is also an employee, eligible for PEHP benefits, the maximum coverage per employee is $318,000.

EMPLOYEE TERM LIFE

☐ **Minimum Group Term Life Coverage** - Provides $18,000 in coverage for employees up to age 66. Minimum Group Term Life is funded by your employer for all eligible employees.

☐ **Basic Group Term-Life Coverage** - Provides $50,000 in coverage for employees up to age 66. Basic Term Life i ncludes the employer paid Minimum of $18,000 for a total of $68,000. No underwriting is req uired if applying within 60 days of hire. After 60 days please complete the Health Statement.

Additional Group Term-Life Coverage - To apply for Additional Term Life Coverage you must be enrolled in Basic Term -Life and complete the Employee Health Statement. This coverage is in addition to Basic Group Term Life Coverage.

Select the amount of Additional Term Life Coverage: ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

SPOUSE TERM LIFE

Select the amount of Spouse Coverage: ☐ $5,000 ☐ $15,000 ☐ $40,000 ☐ $65,000 ☐ $90,000 ☐ $115,000 ☐ $150,000
If applying within 60 days of hire for 15,000 or less a health statement is not required, otherwise complete the Spouse Health Statement.

SPOUSE NAME (last, first, middle initial)	BIRTH DATE (mm/dd/yy)	MARRIAGE DATE (mm/dd/yy/)

DEPENDENT CHILD TERM LIFE

Dependent Group Term Life Coverage is for unmarried children up to age 26. You must be enrolled in Basic or Minimum Group Coverage to be eligible for Dependent Child Term Life. Premium covers all eligible dependent children. A Health Statement is required for each dependent if applying past 60 days from hire, birth of dependent, or event.

Enter the number of eligible dependents to enroll: _____

Coverage Per Child*	☐ $5,000	☐ $7,500	☐ $10,000
Bi-Weekly Premium	.30	.45	.60

*Coverage amount is limited to $1,000 for newborn's up to age 6 months.

Signature required, see Section D.

FOR PEHP USE ONLY
Effective Date: _____ Certificate No.: _____ Minimum: _____
Basic: _____ Additional: _____ Dependent: _____
Verified By: _____ Date: _____

Updated 10-99

Public Employees Health Program

Group Term Life Beneficiary Designation

Employee Name: _____ Social Security Number: _____

Section C - **Beneficiary Designation**

Please enter the beneficiaries for the Employee coverage and Spouse coverage (i f you have applied for Spouse Term Life Coverage). The beneficiary for Dependent Child Term Life coverage is automatically the insured employee.

Please indicate whether the beneficiary is a primary or secondary (death benefi ts are first paid to the primary beneficiary, if the primary beneficiary is deceased benefits would be paid to t he secondary beneficiary). If more than one primary beneficiary is listed, the benefit will be divided equally among th ose listed, unless otherwise instructed on the form. If you do not name a beneficiary, the benefit(s) will be paid to you r estate, as provided for by the plan.

(Check One)		**EMPLOYEE TERM LIFE BENEFICIARIES**			
Primary	Secondary	BENEFICIARY NAME (Last, First, Middle Initial)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE	MAILING ADDRESS (Address / City / State / Zip)

(Check One)		**SPOUSE TERM LIFE BENEFICIARIES**			
Primary	Secondary	BENEFICIARY NAME (Last, First, Middle Initial)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE	MAILING ADDRESS (Address / City / State / Zip)

Section D

Employee Agreement & Signature

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term-Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

EMPLOYEE SIGNATURE	DATE

Please make a copy for your records.

Public Employees Health Program

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004
Enrollment: 801-366-7555 / Toll Free 800-753-7437

State of Utah

Group Term Life
Employee Health Statement

Employee Name: _____ Social Security Number: _____

Section A

Employee Health Statement

Complete all questions in full for yourself. This information is required if applying for Additional Term Life Coverage or if applying for Basic Term Life Coverage after 60 days from hire.

Employee Height (Ft., In.): _____ Employee Weight: _____ Occupation: _____

1. Have you **ever** had symptoms, been diagnosed with, or been treated for:			
	a. High blood pressure	☐ Yes	☐ No
	b. Seizures or convulsions	☐ Yes	☐ No
	c. Mental or nervous conditions	☐ Yes	☐ No
	d. Lung or respiratory disorders	☐ Yes	☐ No
	e. Digestive or rectal disorders	☐ Yes	☐ No
	f. Blood or blood vessel disorders	☐ Yes	☐ No
	g. Urinary tract disorders	☐ Yes	☐ No
	h. Skeletal, spine, joint or muscle disorders	☐ Yes	☐ No
	I. Thyroid, breast or other glandular disorders	☐ Yes	☐ No
	j. Rheumatic fever or heart disorders	☐ Yes	☐ No
	k. Chest pain or circulatory disorders	☐ Yes	☐ No
	l. Reproductive organ disorders	☐ Yes	☐ No
	m. Substance or alcohol abuse	☐ Yes	☐ No
	n. Cancer or tumors	☐ Yes	☐ No
	o. Ulcer	☐ Yes	☐ No
	p. Colitis	☐ Yes	☐ No
	q. Diabetes	☐ Yes	☐ No
2. Have you **ever** had a surgical procedure or been advised to have surgery which has not been completed at this time?		☐ Yes	☐ No
3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years?		☐ Yes	☐ No

4. Have you had or currently have any known physical deformities, or physical or mental impairments, disorders or ill health not mentioned in question #1?		☐ Yes	☐ No
5. Have you ever been denied life or health insurance coverage, or received an increased premium rating for health		☐ Yes	☐ No
6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years?		☐ Yes	☐ No
7. In the past ten years, have you sought or received treatment or advice for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma?		☐ Yes	☐ No
8. Have you ever tested HIV positive?		☐ Yes	☐ No
9. If female, are you pregnant? If yes, expected date of delivery: _____		☐ Yes	☐ No
10. Tobacco Usage			
	a. Do you currently smoke cigarettes? If Yes, _____ per day	☐ Yes	☐ No
	b. Have you ever smoked cigarettes? If Yes, date last smoked? _____	☐ Yes	☐ No
	c. Have you used any tobacco products in the past 10 years?	☐ Yes	☐ No

Give complete details below for all "Yes" answers to above questions. Provide complete names and phone numbers for all physicians.

Question No.	Disease, injury or Medical Condition	Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption)	Treatment Dates		Hospitalized?		Attending Physician (doctor name and telephone number)	Degree of Recovery
			From	To	Yes	No		

Section B

Employee Agreement & Signature

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term-Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

EMPLOYEE SIGNATURE	DATE

Please make a copy for your records.

Updated 10-99

Public Employees Health Program

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State of Utah

Group Term Life
Spouse/Dependent Child Health Statement

Employee Name: _____ Social Security Number: _____

Section A

Spouse or Dependent Child Health Statement

Complete this form for the spouse or one for each dependent (make additional copies if necessary). This information is required if applying for Spouse or Dependent coverage after 60 days from hire date, birth date or marriage date. This is also required for Spouse Coverage $40,000 and above.

Name (Last, First, M.I.): _____ Date of Birth: _____ Height (Ft., In.): _____ Weight: _____

Relationship To Employee: _____ Occupation: _____

1. Have you **ever** had symptoms, been diagnosed with, or been treated for:			
a. High blood pressure	☐ Yes	☐ No	
b. Seizures or convulsions	☐ Yes	☐ No	
c. Mental or nervous conditions	☐ Yes	☐ No	
d. Lung or respiratory disorders	☐ Yes	☐ No	
e. Digestive or rectal disorders	☐ Yes	☐ No	
f. Blood or blood vessel disorders	☐ Yes	☐ No	
g. Urinary tract disorders	☐ Yes	☐ No	
h. Skeletal, spine, joint or muscle disorders	☐ Yes	☐ No	
I. Thyroid, breast or other glandular disorders	☐ Yes	☐ No	
j. Rheumatic fever or heart disorders	☐ Yes	☐ No	
k. Chest pain or circulatory disorders	☐ Yes	☐ No	
l. Reproductive organ disorders	☐ Yes	☐ No	
m. Substance or alcohol abuse	☐ Yes	☐ No	
n. Cancer or tumors	☐ Yes	☐ No	
o. Ulcer	☐ Yes	☐ No	
p. Colitis	☐ Yes	☐ No	
q. Diabetes	☐ Yes	☐ No	
2. Have you **ever** had a surgical procedure or been advised to have surgery which has not been completed at this time?	☐ Yes	☐ No	
3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years?	☐ Yes	☐ No	
4. Have you had or currently have any known physical deformities, or physical or mental impairments, disorders or ill health not mentioned in question #1?	☐ Yes	☐ No	
5. Have you been denied life or health insurance coverage, or received an increased premium rating for health reasons?	☐ Yes	☐ No	
6. Have you ever had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years?	☐ Yes	☐ No	
7. In the past ten years, have you sought or received treatment or advice for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma?	☐ Yes	☐ No	
8. Have you ever tested HIV positive?	☐ Yes	☐ No	
9. If female, are you pregnant? If yes, expected date of delivery: _____	☐ Yes	☐ No	
10. Tobacco Usage			
a. Do you currently smoke cigarettes? If Yes, _____ per day	☐ Yes	☐ No	
b. Have you ever smoked cigarettes? If Yes, date last smoked? _____	☐ Yes	☐ No	
c. Have you used any tobacco products in the past 10 years?	☐ Yes	☐ No	

Give complete details below for all "Yes" answers to above questions. Provide complete names and phone numbers for all physicians.

Question No.	Disease, injury or Medical Condition	Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption)	Treatment Dates		Hospitalized?		Attending Physician (doctor name and telephone number)	Degree of Recovery
			From	To	Yes	No		

Section B

Employee Agreement & Signature

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable; By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

EMPLOYEE SIGNATURE	DATE	SPOUSE SIGNATURE (Required if applying for Spouse Term-Life Coverage)	DATE

Please make a copy for your records.

Public Employees Health Program

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State of Utah
Group Term Life
Dependent Child Health Statement

Employee Name: _____ Social Security Number: _____

Section A

Dependent Child Health Statement

Complete this form if applying for Dependent Child Term Life coverage. One form is required for each dependent if applying for Dependent coverage after 60 days from hire date, birth date, marriage date, or adoption/placement.

Name (Last, First, M.I.): _____ Date of Birth: _____ Height (Ft., In.): _____ Weight: _____

Relationship To Employee: _____ Occupation: _____

1. Have you **ever** had symptoms, been diagnosed with, or been treated for:		
a. High blood pressure	☐ Yes	☐ No
b. Seizures or convulsions	☐ Yes	☐ No
c. Mental or nervous conditions	☐ Yes	☐ No
d. Lung or respiratory disorders	☐ Yes	☐ No
e. Digestive or rectal disorders	☐ Yes	☐ No
f. Blood or blood vessel disorders	☐ Yes	☐ No
g. Urinary tract disorders	☐ Yes	☐ No
h. Skeletal, spine, joint or muscle disorders	☐ Yes	☐ No
I. Thyroid, breast or other glandular disorders	☐ Yes	☐ No
j. Rheumatic fever or heart disorders	☐ Yes	☐ No
k. Chest pain or circulatory disorders	☐ Yes	☐ No
l. Reproductive organ disorders	☐ Yes	☐ No
m. Substance or alcohol abuse	☐ Yes	☐ No
n. Cancer or tumors	☐ Yes	☐ No
o. Ulcer	☐ Yes	☐ No
p. Colitis	☐ Yes	☐ No
q. Diabetes	☐ Yes	☐ No
2. Have you **ever** had a surgical procedure or been advised to have surgery which has not been completed at this time?	☐ Yes	☐ No
3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years?	☐ Yes	☐ No

4. Have you had or currently have any known physical deformities, or physical or mental impairments, disorders or ill health not mentioned in question #1?	☐ Yes	☐ No
5. Have you ever been denied life or health insurance coverage, or received an increased premium rating for health	☐ Yes	☐ No
6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years?	☐ Yes	☐ No
7. In the past ten years, have you sought or received treatment or advice for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma?	☐ Yes	☐ No
8. Have you ever tested HIV positive?	☐ Yes	☐ No
9. If female, are you pregnant? If yes, expected date of delivery: _____	☐ Yes	☐ No
10. Tobacco Usage		
a. Do you currently smoke cigarettes? If Yes, _____ per day	☐ Yes	☐ No
b. Have you ever smoked cigarettes? If Yes, date last smoked? _____	☐ Yes	☐ No
c. Have you used any tobacco products in the past 10 years?	☐ Yes	☐ No

Give complete details below for all "Yes" answers to above questions. Provide complete names and phone numbers for all physicians.

Question No.	Disease, injury or Medical Condition	Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption)	Treatment Dates		Hospitalized?		Attending Physician (doctor name and telephone number)	Degree of Recovery
			From	To	Yes	No		

Section B

Employee Agreement & Signature

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EMPLOYEE SIGNATURE	DATE

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State of Utah
Group Term Life
Dependent Child Health Statement

Employee Name: _____ Social Security Number: _____

Section A

Dependent Child Health Statement

Complete this form if applying for Dependent Child Term Life coverage. One form is required for each dependent if applying for Dependent coverage after 60 days from hire date, birth date, marriage date, or adoption/placement.

Name (Last, First, M.I.): _____ Date of Birth: _____ Height (Ft., In.): _____ Weight: _____

Relationship To Employee: _____ Occupation: _____

1. Have you **ever** had symptoms, been diagnosed with, or been treated for:		
a. High blood pressure	☐ Yes	☐ No
b. Seizures or convulsions	☐ Yes	☐ No
c. Mental or nervous conditions	☐ Yes	☐ No
d. Lung or respiratory disorders	☐ Yes	☐ No
e. Digestive or rectal disorders	☐ Yes	☐ No
f. Blood or blood vessel disorders	☐ Yes	☐ No
g. Urinary tract disorders	☐ Yes	☐ No
h. Skeletal, spine, joint or muscle disorders	☐ Yes	☐ No
I. Thyroid, breast or other glandular disorders	☐ Yes	☐ No
j. Rheumatic fever or heart disorders	☐ Yes	☐ No
k. Chest pain or circulatory disorders	☐ Yes	☐ No
l. Reproductive organ disorders	☐ Yes	☐ No
m. Substance or alcohol abuse	☐ Yes	☐ No
n. Cancer or tumors	☐ Yes	☐ No
o. Ulcer	☐ Yes	☐ No
p. Colitis	☐ Yes	☐ No
q. Diabetes	☐ Yes	☐ No
2. Have you **ever** had a surgical procedure or been advised to have surgery which has not been completed at this time?	☐ Yes	☐ No
3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years?	☐ Yes	☐ No

4. Have you had or currently have any known physical deformities, or physical or mental impairments, disorders or ill health not mentioned in question #1?	☐ Yes	☐ No
5. Have you ever been denied life or health insurance coverage, or received an increased premium rating for health	☐ Yes	☐ No
6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years?	☐ Yes	☐ No
7. In the past ten years, have you sought or received treatment or advice for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma?	☐ Yes	☐ No
8. Have you ever tested HIV positive?	☐ Yes	☐ No
9. If female, are you pregnant? If yes, expected date of delivery: _____	☐ Yes	☐ No
10. Tobacco Usage		
a. Do you currently smoke cigarettes? If Yes, _____ per day	☐ Yes	☐ No
b. Have you ever smoked cigarettes? If Yes, date last smoked? _____	☐ Yes	☐ No
c. Have you used any tobacco products in the past 10 years?	☐ Yes	☐ No

Give complete details below for all "Yes" answers to above questions. Provide complete names and phone numbers for all physicians.

Question No.	Disease, injury or Medical Condition	Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption)	Treatment Dates		Hospitalized?		Attending Physician (doctor name and telephone number)	Degree of Recovery
			From	To	Yes	No		

Section B

Employee Agreement & Signature

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EMPLOYEE SIGNATURE	DATE

Please make a copy for your records.